PLEASE PRINT

PATIENT'S NAME: ____

DATE OF BIRTH: ______________ GENDER: ☐ MALE ☐ FEMALE

ADDRESS: ____

CITY: _______________________________ STATE: __________ ZIPCODE: _____________

HOME PHONE: ________________ CELL PHONE: ______________________ WORK PHONE: ___________

OCCUPATION: ________________________ EMPLOYERS NAME: ________________________________

SPOUSE/ PARENT/ GUARDIAN NAME: ____

PARENT/ GUARDIAN ADDRESS: ____

CITY: _______________________________ STATE: __________ ZIPCODE: _____________

REFERRED BY: ____________________________ GENERAL DENTIST: ____________________________

****

MEDICAL HISTORY

DO YOU HAVE OR HAVE YOU HAD ANY OF THE FOLLOWING? (Please check if YES)

☐ HEART DISEASE/ATTACK
☐ HEART MURMUR
☐ HEART SURGERY
☐ PACEMAKER
☐ MITRAL VALVE PROLAPSE
☐ RHEUMATIC FEVER
☐ RHEUMATIC HEART DISEASE
☐ STROKE
☐ PROSTHETIC HEART VALVE
☐ ANGINA
☐ CONGENITAL HEART DEFEACT
☐ OTHER HEART CONDITIONS
____
____
☐ HIGH BLOOD PRESSURE
☐ TUBERCULOSIS
☐ EMPHYSEMA
☐ ASTHMA
☐ SINUS PROBLEMS/ALLERGIES
☐ HEPATITIS – TYPE: A B or C
☐ JOINT REPLACEMENT
☐ PARKINSON'S DISEASE

☐ STOMACH ULCERS
☐ DIABETES
☐ MRSA
☐ STAPH
☐ THYROID DISORDERS
☐ STEROID THERAPY
☐ EPILIEPSY
☐ FAINTING/SEIZURES
☐ BLOOD TRANSFUSION
☐ BLEEDING PROBLEMS
☐ ANTICOAGULANTS (BLOOD THINNERS)
☐ ANEMIA (LOW BLOOD)
☐ LEUKEMIA
☐ HEARING IMPAIRED
☐ LIVER DISEASE
☐ TMJ PROBLEMS
☐ CANCER/TUMOR
☐ VENEREAL DISEASE
☐ HIV POSITIVE
☐ AIDS
☐ DRUG DEPENDENCY

☐ SURGERY IN THE PAST YEAR DATE: ____________

REASON: ______________________________________
____

OTHER MEDICAL CONDITIONS/CONCERNS: __________
____
____
____

ARE YOU TAKING ANY MEDICATIONS? ☐ YES ☐ NO

PLEASE LIST YOUR MEDICATIONS:

____
____
____

DO YOU PREMEDICATE WITH ANTIBIOTICS BEFORE DENTAL PROCEDURES? ☐ YES ☐ NO

IF YES, NAME OF ANTIBIOTIC ___________________

ARE YOU ALLERGIC TO:

☐ ASPIRIN ☐ PENICILLIN ☐ LATEX ☐ SULFA
☐ CODEINE ☐ IBUPROFEN ☐ LOCAL ANESTHETIC

OTHERS (Please list): ________________________
____

ARE YOU PREGNANT? ☐ YES ☐ NO

ARE YOU UNDER THE CARE OF A PHYSICIAN? ☐ YES ☐ NO
(If YES, please list reason and physician's name)

____
____

DO YOU WANT NITROUS OXIDE (LAUGHING GAS)?
☐ YES ☐ NO (Your insurance may not cover this)

TOOTH HISTORY

ARE YOU CURRENTLY IN PAIN? ☐ YES ☐ NO

IF YES, PLEASE RATE THE DISCOMFORT
(1=slight & 10=unbearable) ____ / 10

THE TOOTH IS SENSITIVE TO: ☐ TEMPERATURE
☐ PRESSURE ☐ BITING ☐ OTHER: ______________

DO YOU HAVE OR HAVE YOU HAD SWELLING OR DRAINAGE? ☐ YES ☐ NO

COMMENTS: ____________________________________
____

Registration & Medical History

I hereby acknowledge I have read and I understand the questions above. I acknowledge that I have answered them to the best of my ability. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my doctor, or any other member of his/her staff responsible for any errors or omissions that I have made in the completion of this form.

X____

Patient Signature

Fees & Payments

I hereby acknowledge I have read and I understand the Financial Policy.

X____

Patient Signature

Notice of Privacy Practice Policy

I hereby acknowledge a copy of the Notice of Privacy Practice has been made available to me online or in office by request. I have been given the opportunity to ask any questions I may have regarding this Notice.

X____

Patient Signature

COVID-19 Screening

I hereby acknowledge I have read and understand the COVID-19 Screening set forth by this office.

X____

Patient Signature

CONSENT FOR ENDODONTIC THERAPY

Please review the following consent form. You will be required to sign this form prior to the initiation of treatment. Your signature does not commit you to any treatment.

I understand the root canal therapy is a procedure that retains a tooth, which may otherwise require extraction. As a specialty practice, this office performs only endodontic therapy and associated surgery. Treatment will require a series of x-rays and may require multiple visits. It is important you keep your scheduled appointments or infection may reoccur. In most cases there is only mild discomfort after treatment. This usually lasts 2-4 days and is usually controlled by ibuprofen, Tylenol or a prescribed medication. Although root canal therapy has a very high degree of success, results cannot be guaranteed. During treatment, complications may be discovered which make treatment difficult, impossible, or which may require dental surgery. The most common complications include but are not limited to:

-continued infection
-blocked canals due to natural calcification, filings, prior treatment, or separated instruments
-pain requiring use of medication
-fracture of the root or crown of the tooth during and after treatment
-tenderness of the tooth following treatment or due to gum disease, physical stress from chewing, or poor healing of your body

Occasionally, a tooth which has had root canal therapy, may require retreatment, surgery, or even extraction. During and following treatment, the tooth may be brittle and subject to fracture. A restoration (filling), crown and/or post and core will be necessary to restore the tooth, and your general dentist will perform these procedures. If the tooth already has a crown, it may have to be replaced due to decay, fracture, or loss of structural support. The restoration of your tooth (filing, crown, etc.) will be performed by your general dentist and our fee **does not** include these services. During endodontic treatment, there is the possibility of instrument separation within the root canals, perforations (extra openings), damage to bridges, existing fillings, crowns or porcelain veneers, missed canals, loss of tooth structure in gaining access to canals, and fractured teeth. Also, there are times when a minor surgical procedure may be indicated or when the tooth may not be amenable to endodontic treatment at all. Other treatment choices include no treatment, a waiting period for more definitive symptoms to develop, tooth extraction, or extraction paired with restorative or implant possibilities. Risks involved in those choices might include, but are not limited to, pain, infection, swelling, loss of teeth, and infection to other areas.

Occasionally, a patient may experience side effects or reactions due to medications used during or after treatment. Medications prescribed for discomfort and/or sedation may cause drowsiness, which can be increased by the use of alcohol or other drugs. We advise you do not operate a motor vehicle or any hazardous device while taking such medications. In addition, certain medications may cause allergic reactions, such as hives or intestinal discomfort. If any of these problems occur, call our office immediately. It is the patient's responsibility to report any changes in his/her medical history when known.

I fully understand the above statements in this consent form.

Furthermore, I give this office my permission to voice record, tape digitally, videotape and/or take 35mm and/or digital photos of my procedure for purposes of completing my medical record and/or for patient education.

Note: All medical records will be kept strictly confidential.

X____

Patient Signature